

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4920

CERTIFICATE OF DEATH

Reg. Dist. No.

04908

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>PITTSVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JULIA</u> First <u>ELIZABETH</u> Middle <u>Austin</u> Last		4. DATE OF DEATH <u>April</u> Month <u>14</u> Day <u>1961</u> Year					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-26-1892</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>CONN.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES BRAINARD</u>				14. MOTHER'S MAIDEN NAME <u>NELLIE UPDIKE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NOVE</u>		INFORMANT Address <u>Elmer Austin, Pittsville Ind.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260x Cardiac Infarction.</u> DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Diabetes Mellitus</u> DUE TO						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/14/61</u> , 19 <u>61</u> , to <u>4/14/61</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>4/14/61</u> , 19 <u>61</u> , and that death occurred at <u>9:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>CARRIE HEARN</u> M.D.				ADDRESS (Street, city or town, state) <u>SALISBURY - MD.</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>CARRIE HEARN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-17-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Belmon</u>		22d. LOCATION (City, town, or county) (State) <u>Belmon, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Marvel Co - Belmon, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>APR 17 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

1930

CHARLES BRADY - DO
BORN - 1902
DIED - 1930
AGE - 28
CAUSE OF DEATH -
PLACE OF DEATH -
DATE OF DEATH -
SIGNED -
WITNESSES -
REGISTRAR -

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04909

4921

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salesbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEWARK</u> d. STREET ADDRESS <u>23X-2</u>			
3. NAME OF DECEASED (Type or print) <u>Christine</u> First <u>Banks</u> Middle Last 4. DATE OF DEATH <u>April 13</u> Month Day Year <u>1961</u>				5. SEX <u>Female</u> 6. COLOR OR RACE <u>Negro</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>APRIL 5, 1961</u> 9. AGE (In years last birthday) <u>8</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Solomon Banks</u>			
14. MOTHER'S MAIDEN NAME <u>Margaret Christopher</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>—</u> INFORMANT Address <u>Father - Solomon Banks - Newark, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Neonatal Tetanus (not bacteriologically proven)</u> DUE TO (b) <u>061X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>—</u> DUE TO (b) <u>—</u> DUE TO (c) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH <u>approx 36 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>4/12</u> , 19 <u>61</u> , to <u>4/13</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>4/13</u> , 19 <u>61</u> , and that death occurred at <u>9:50 PM</u> , from the causes and on the date stated above.			
21. ADDRESS (Street, city or town, state) <u>—</u>				21. DATE SIGNED <u>4/14/61</u>			
ACTUAL SIGNATURE <u>Alfred C. Green</u> M.D. <u>Medical Center</u>				PHYSICIAN'S NAME (Type) <u>Salesbury, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-15-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lot of Archie Banks</u>		22d. LOCATION (City, town, or county) (State) <u>Newark Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE (Father) <u>Solomon Banks - Newark, Md.</u> ADDRESS <u>—</u>				24a. REG'D BY REGISTRAR <u>APR 19 1961</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

4000243XV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

4922

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04910

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. STREET ADDRESS 615 Camden Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDITH Middle MARY Last BERRYMAN		4. DATE OF DEATH Month APRIL Day 13th Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 28, 1905
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 10 Days 19	
IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee-Women's Clothing Store		10b. KIND OF BUSINESS OR INDUSTRY Pittsburgh, Pa.	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Thomas Miller		14. MOTHER'S MAIDEN NAME Ann Catherine Bentz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mrs. Margaret M. White (Sister) Address 615 Camden Ave. Salisbury, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Convulsions DUE TO 170X Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Convulsions of Rt. Brain DUE TO (c) 	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 		INTERVAL BETWEEN ONSET AND DEATH months year	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a. m. N/A p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) N/A (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-22 19 55 to 4-13 19 61 , that (I) (we) last saw the deceased alive on 4-13 19 61 , and that death occurred at 6:45 P.M. on the causes and on the date stated above.			
22a. SIGNATURE Earl L. Royer		22b. DATE SIGNED April 15 / 1961	
22c. PHYSICIAN'S NAME (Type) Dr. Earl L. Royer		22d. ADDRESS 407 Camden Ave. Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 17, 1961	
23c. NAME OF CEMETERY OR CREMATORY Wicomico Mem. Park		23d. LOCATION (City, town, or county) Salisbury, Maryland (State)	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND		25a. REC'D BY REGISTRAR DATE APR 18 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Howard	

(M)

1932

CERTIFICATE OF DEATH

Decedent's Name: [illegible] Date of Death: [illegible]

Place of Birth: [illegible] Date of Birth: [illegible]

Place of Death: [illegible] Date of Death: [illegible]

Sex: [illegible] Race: [illegible]

Marital Status: [illegible] Date of Marriage: [illegible]

Occupation: [illegible] Cause of Death: [illegible]

Signature of Physician: [illegible]

Signature of Registrar: [illegible]

Signature of Coroner: [illegible]

Signature of Medical Examiner: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

VR A15 (4)
15M 9/59

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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4923
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
04911

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	c. LENGTH OF STAY IN 1b X	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury (Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 1 (Union)		d. STREET ADDRESS R.D.# 1 (Union)	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WILLIAM Middle THOMAS Last BROWN		4. DATE OF DEATH Month APRIL Day 6th Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 11, 1881
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 4 Days 25 Hours Min. 	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Wicomico Co. Maryland
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Anthoney Marion Brown	
14. MOTHER'S MAIDEN NAME Esther Florence Pryor		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 		17. INFORMANT Mrs. Hannah Tabitha (Farlow) Brown (Wife) R.D.#1 (Union) Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Cirrhosis DUE TO 450-0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive Heart Failure DUE TO 6 months (c) Generalized arteriosclerosis DUE TO ?		INTERVAL BETWEEN ONSET AND DEATH 4 months 6 months ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour o. m. N/A 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) (County) (State) N/A	
21. I certify that (I) (this hospital) attended the deceased from October 31, 1960 to April 6, 1961 , that (I) (we) last saw the deceased alive on April 3, 1961 , and that death occurred at 1:25 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Robert T. Adkins		22b. DATE April 6, 1961	
22c. PHYSICIAN'S NAME (Type) Dr. Robert T. Adkins		22d. ADDRESS Fruitland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 8, 1961	
23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		25a. REC'D BY REGISTRAR APR 10 '61	
ADDRESS SALISBURY MARYLAND		25b. REGISTRAR'S SIGNATURE Arthur L. Hanes	

CERTIFICATE OF DEATH

1953

M



1



1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Item 18 File 287-5-25-61														
MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
4924 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04912														
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 612 Hill St					d. STREET ADDRESS 612 Hill St									
3. NAME OF DECEASED (Type or print) First FLOSSIE Middle MAE Last CLARK					4. DATE OF DEATH Month APRIL Day 26 Year 1961									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 13, 1911		9. AGE (In years last birthday) 49 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A		IF UNDER 1 YEAR Months Days Hours Min.						
13. FATHER'S NAME Peter G. Mercer					14. MOTHER'S MAIDEN NAME Alice Butler									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO.					17. INFORMANT Mr. Milton T. Clark (Husband) Address 612 Hill St Salisbury, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 322.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute alcoholism DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH Sudden Hours				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE Dr. Earl L. Royer					CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) 407 Camden Ave. Salisbury, Md					M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
					DATE SIGNED April 28 /1961									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 1, 1961		22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or country) (State) Salisbury, Maryland								
23. FUNERAL DIRECTOR HOLLOWAY & COMPANY					ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR MAY 3 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kline					

MEDICAL CERTIFICATION



NOV 21 1961

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04913

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HENRY T. COOPER</u> First Middle Last				4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 30, 1883</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Hiram Cooper</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jarman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>217-36-1482</u>		INFORMANT Address <u>Harry Cooper Willards, Md. RFD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) <u>4 days</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-13</u> , 19 <u>61</u> , to <u>4-19</u> , 19 <u>61</u> (that I last saw the deceased alive on <u>4-19</u> , 19 <u>61</u> , and that death occurred at <u>4 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Willard R. Ellis</u> M.D.				ADDRESS (Street, city or town, state) <u>Willards Md.</u> DATE SIGNED <u>4-19-61</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, or other disposition (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/21/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cooper Family</u>		22d. LOCATION (City, town, or county) (State) <u>Willards Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Peter H. Haley</u> ADDRESS <u>Selbyville Del.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 21 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

CERTIFICATE OF DEATH

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JULY 30, 1982

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4926

Items 9, 11 & 12 Film G286 5/1/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No.

04914

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>md</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>4 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Olle Preston</u> First Middle Last				4. DATE OF DEATH <u>CORBIN</u> Month <u>APRIL</u> Day <u>18</u> Year <u>1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>COLORED</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-16-03</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Luke Corbin</u>				14. MOTHER'S M maiden NAME <u>Clara Wright</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>27-10-2155</u>			
17. INFORMANT <u>Jerrie Corbin</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Lobar Pneumonia</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes mellitus</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>Indefinite</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1 Apr</u> 19 <u>60</u> to <u>18 Apr</u> 19 <u>61</u> , that I last saw the deceased alive on <u>17 Apr</u> 19 <u>61</u> , and that death occurred at <u>12:35</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>652 W. Main Salisbury, Md</u> DATE SIGNED <u>18 Apr 61</u> ACTUAL SIGNATURE <u>J. F. Farnell</u> M.D. PHYSICIAN'S NAME (Type) <u>Salisbury, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-23-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>West End Office</u>		22d. LOCATION (City, town, or county) (State) <u>West End Office md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Booker M. West</u>				ADDRESS <u>Salisbury md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 25 '61</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

4927

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04915

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b Since 4/13/61	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denton		d. STREET ADDRESS Denton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pine Bluff State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Howard Middle Corkran Last Corkran		4. DATE OF DEATH Month April Day 14 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 7, 1887
9. AGE (In years lost birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min. 73	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard T. Corkran		14. MOTHER'S MAIDEN NAME Anne Sharp	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Records of Pine Bluff State Hospital	
17. INFORMANT Records of Pine Bluff State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Cor Pulmonale IMMEDIATE CAUSE (a) 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Chronic Obstructive Emphysema (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 yr. 10 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Tuberculosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 13, 1961 to April 14, 1961 , that (I) (we) last saw the deceased alive on April 13, 1961 , and that death occurred at 4:30a M, from the causes and on the date stated above.			
22a. SIGNATURE E. P. Ritchings		22b. DATE 4/14/61	
22c. PHYSICIAN'S NAME (Type) E. P. Ritchings		22d. ADDRESS Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF Apr. 16, 1961	
23c. NAME OF CEMETERY OR CREMATORY Denton		23d. LOCATION (City, town, or county) (State) Denton Md	
24. FUNERAL DIRECTOR'S SIGNATURE John H. Moore		25a. REC'D BY REGISTRAR APR 19 61	
ADDRESS John H. Moore		25b. REGISTRAR'S SIGNATURE John H. Moore	

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CERTIFICATE OF DEATH

5553

Blank certificate form with horizontal lines for text entry.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4928

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04916

1 FOR STATE HEALTH DEPT

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 722 N. Westover Circle				d. STREET ADDRESS 722 N. Westover Circle			
3. NAME OF DECEASED (Type or print) Artelia Cottman				4. DATE OF DEATH 4-8-61 19 48			
5. SEX F		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH May 5, 1920	
9. AGE (In years last birthday) 40 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY State Teachers College		11. BIRTHPLACE (State or foreign country) U.S.A	
12. CITIZEN OF WHAT COUNTRY? U.S.A				13. FATHER'S NAME Garrison White			
14. MOTHER'S MAIDEN NAME Lillian Dashiell				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. 491X				17. INFORMANT Ralph White 120 First St, Salisbury Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia DUE TO (b) 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Earl L. Royer, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) 407 Camden Ave. Salisbury, Md.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial				22b. DATE THEREOF 4/12/1961			
22c. NAME OF CEMETERY OR CREMATORY Green Acres				22d. LOCATION (City, town, or country) (State) Salisbury Md.			
23. FUNERAL DIRECTOR Clinton F. Stewart Salisbury Md.				24e. REC'D BY REGISTRAR APR 17 '61			
24f. REGISTRAR'S SIGNATURE Arthur S. Kears				DATE APR 17 '61			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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13-11-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4929

CERTIFICATE OF DEATH

Reg./Dist. No. 04917

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>19 days</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>23X-2</u>					
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>G.</u> Last <u>Crippen</u>				4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>1961</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 8 1961</u>			
9. AGE (In years last birthday) <u>19</u> yrs.		IF UNDER 1 YEAR Months <u>19</u> Days <u>19</u> Hours <u>19</u> Min.		IF UNDER 24 HRS.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>					
11. BIRTH PLACE (State or foreign country) <u>Stocketon, md</u>				12. CITIZEN OF WHAT COUNTRY? <u>md</u>					
13. FATHER'S NAME <u>Willie Teagle</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Crippen</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u> INFORMANT <u>Miss Virginia Crippen, Stocketon, md</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO <u>053.3</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bacteremia, acute</u> DUE TO <u>1 to 2 day</u> (c) <u>Meningitis - acute</u> DUE TO <u>1 day</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prematurity</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>4/8</u> , 19 <u>61</u> , to <u>4/27</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>4/27</u> , 19 <u>61</u> , and that death occurred at <u>1:45</u> PM, from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <u>Salisbury md</u> DATE SIGNED <u>4/27/61</u>									
ACTUAL SIGNATURE <u>William C. Morgan M.D.</u>									
PHYSICIAN'S NAME (Type) <u>William C. Morgan</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF <u>April 27/61</u>					
22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Cemetery</u>				22d. LOCATION (City, town, or county) <u>Stocketon md</u> (State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton E. Shuman</u> ADDRESS <u>Shawville, md</u>				24a. REC'D BY REGISTRAR <u>MAY 1 '61</u> DATE					
				24b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>					

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04918

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Custis</u> Middle <u>Curtis</u> Last		4. DATE OF DEATH <u>April</u> Month <u>9</u> Day <u>1961</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 3 - 1922</u>
9. AGE (In years and birthday) <u>39</u> yrs.		10. UNDER 1 YEAR Months Days Hours Min.	11. UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>fisher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Geo Custis</u>		14. MOTHER'S MAIDEN NAME <u>Cordie Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>?</u> INFORMANT <u>Henry Custis</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 332X IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> (c) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>und</u> <u>und</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not-while at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 4, 1960</u> to <u>April 9, 1961</u> , that I last saw the deceased alive on <u>April 5, 1961</u> , and that death occurred at <u>3:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. Herbert Semple</u> M.D.		ADDRESS (Street, city or town, state) <u>400 E. Church St. Salisbury, Md (Maryland)</u> DATE SIGNED <u>4/10/61</u>	
PHYSICIAN'S NAME (Type) <u>G. Herbert Semple</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>4-14-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Acres Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Booker McEwen</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>APR 12 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>

CERTIFICATE OF DEATH

1918

(M)

(2)

[Faint, mostly illegible handwritten text, likely a death certificate form with fields for name, age, sex, cause of death, etc.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8 & 9 Film G284 4/10/61 1wk

CERTIFICATE OF DEATH

Reg. Dist. No. 04919

4931

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALESBURY</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL Hospital</u>				d. STREET ADDRESS <u>R.F.D</u>			
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>I.</u> Last <u>DAVIS</u>				4. DATE OF DEATH Month <u>4</u> Day <u>1</u> Year <u>1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 23, 1872</u>	9. AGE (In years last birthday) <u>88</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FISH-CLAMS</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>CHARLES EDWARD DAVIS</u>				14. MOTHER'S MAIDEN NAME <u>MAHALA PURNELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NO</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Anterior-schroffe Heart Disease</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>conduction</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>2-2</u> , 19 <u>61</u> , to <u>4-1</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>4-1</u> , 19 <u>61</u> , and that death occurred at <u>9:32 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Willard R. Ellis Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Salesbury, Md.</u> DATE SIGNED <u>4-1-61</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/4/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>TAYLORVILLE</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN (RFD) MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u>				ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 6 '61</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



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CERTIFICATE OF DEATH

1931

10

WALTER E. BROWN

June 10

1931

88

U.S.A.

Walter E. Brown

Walter E. Brown

Walter E. Brown

1931

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Walter E. Brown

W.E.B.

Walter E. Brown

Walter E. Brown

Walter E. Brown

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4932

04920

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Powellville		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Powellville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) XXXXXX				d. STREET ADDRESS XXX		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HETTIE E. DENNIS				4. DATE OF DEATH Month April Day 20 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28, 1886		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Isaac Lewis				14. MOTHER'S MAIDEN NAME Sallie Jane Jones			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) X		16. SOCIAL SECURITY NO. XXXX		17. INFORMANT Norman Dennis Powellville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adeno-carcinoma (generalized intestinal cancer) 153.9 DUE TO (b) (was operated at P.G. Hospital Salisbury and) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) —						INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) none							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m. —	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from August , 1959, to day of death , 1961, that (I) (we) last saw the deceased alive on April 20 , 1961, and that death occurred at 6 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Frank Lewis				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Frank Lewis				22d. ADDRESS Willards Maryland.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/23/61		23c. NAME OF CEMETERY OR CREMATORY Persons		23d. LOCATION (City, town or county) (State) Salisbury Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley Salisbury, Del.				25a. REC'D BY REGISTRAR APR 24 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4933 Item 14 Film G286 5/1/61 iwk
CERTIFICATE OF DEATH

Reg. Dist. No. 04921

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>Newark</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>R.F.D.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph GREENSBERRY Downs</u>				4. DATE OF DEATH Month Day Year <u>APRIL 24 1961</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 24, 1879</u>	9. AGE (In years lost birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>PITTSVILLE MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH G. DOWNS</u>				14. MOTHER'S MAIDEN NAME <u>MARION BAILEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		INFORMANT Address <u>MISS. FRANCES DOWNS NEWARK MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) _____ (c) _____ DUE TO _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-20</u> , 19 <u>61</u> , to <u>4-24</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>4-24</u> , 19 <u>61</u> , and that death occurred at <u>8:00 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter R. Ellis</u>		M.D. <u>Salisbury, Md.</u>		ADDRESS (Street, city or town, state) <u>424-G</u>		DATE SIGNED <u>4-24-61</u>	
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/26/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u>		ADDRESS <u>Berlin Md.</u>		24a. REC'D BY REGISTRAR <u>APR 27 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

(M)

1983

CERTIFICATE OF DEATH

1983

Deceased

John

Henry

1937

John Henry

1937

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04922

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1103 E. Church St.				d. STREET ADDRESS 1103 E. Church St.			
3. NAME OF DECEASED (Type or print) First Margaret Middle H. Last Dryden				4. DATE OF DEATH Month April Day 18 Year 19 61			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 7, 1910		9. AGE (In years last birthday) 50 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Worker		10b. KIND OF BUSINESS OR INDUSTRY Officed		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Humphreys				14. MOTHER'S MAIDEN NAME Maddie Layfield			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-07-2769		17. INFORMANT Address Mrs James Hurley Salisbury, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Heart Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Atherosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 8 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 7, 1960 , to 4/18, 1961 , that I last saw the deceased alive on 4/16, 1961 , and that death occurred at 7:50 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE David J. Schuman		M.D. Salisbury Md.		ADDRESS (Street, city or town, state) Salisbury Md.		DATE SIGNED 4/21/61	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4-21-1961		22c. NAME OF CEMETERY OR CREMATORY St. Andrew Cemetery		22d. LOCATION (City, town, or county) (State) Princess Anne, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Levin R. Wilson				ADDRESS Princess Anne, Md.		24a. REC'D BY REGISTRAR DATE APR 24 '61	
				24b. REGISTRAR'S SIGNATURE Clifton L. Hines			

CERTIFICATE OF DEATH

1932

PLACE OF DEATH HOME		SEX MALE	
AGE 68 YEARS		RACE WHITE	
DATE OF DEATH JANUARY 15, 1932		TIME OF DEATH 11:00 A.M.	
PLACE OF BIRTH BALTIMORE, MARYLAND		OCCUPATION RETIRED	
NAME OF DECEASED JAMES H. HARRIS		NAME OF NEXT OF KIN MARY H. HARRIS	
ADDRESS 1234 E. BALTIMORE ST. BALTIMORE, MARYLAND		CAUSE OF DEATH HEART DISEASE	
MEDICAL HISTORY HYPERTENSION, CORONARY ARTERY DISEASE		MANNER OF DEATH NATURAL	
SIGNATURE OF PHYSICIAN J. H. HARRIS		SIGNATURE OF REGISTRAR J. H. HARRIS	
SIGNATURE OF WITNESSES MARY H. HARRIS		SIGNATURE OF DECEASED JAMES H. HARRIS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland		c. LENGTH OF STAY IN 1b X Fruitland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Main St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MATTIE Middle ESTELLE Last DRYDEN		4. DATE OF DEATH Month April Day 8th Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20-1878
9. AGE (In years lost birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 8 Days 24 Hours 15 Min.	11. IF UNDER 24 HRS. Months 8 Days 24 Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work-Retired		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Somerset Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George Powell		14. MOTHER'S MAIDEN NAME Martha Dryden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 12-308-1061	
17. INFORMANT Mrs. Katherine D. Short (Daughter)		Address Main St Fruitland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Congestive Heart Failure DUE TO (b) generalized arteriosclerosis DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute and Chronic Cholecystitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a. m. N/A p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) (County) (State) N/A	
21. I certify that (I) (this hospital) attended the deceased from 3/15 1960 to April 8 1961 , that (I) (we) lost saw the deceased alive on April 8 1961 , and that death occurred at 12:30 P. M. from the causes and on the date stated above.		22a. SIGNATURE Robert T. Adkins	
22c. PHYSICIAN'S NAME (Type) Dr. Robert T. Adkins		22b. DATE SIGNED April 10-1961	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 11, 1961	
23c. NAME OF CEMETERY OR CREMATORY Quinton Church Cemetery-Somerset Co., Maryland		23d. LOCATION (City, town, or county) (State) Fruitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		25a. REC'D BY REGISTRAR APR 13 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Evans		25c. DATE APR 13 '61	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
SM 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Item 8 Film 0286 5/5/61 ink											
1. PLACE OF DEATH a. COUNTY Wicomico				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron				c. LENGTH OF STAY IN 1b MARYLAND			
3. NAME OF DECEASED (Type or print) Julia Jane Elliott				4. DATE OF DEATH Month 4 Day 24 Year 61				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 12, 1871 April 24, 1961		9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months 4 Days 24	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home				11. BIRTHPLACE (State or foreign country) Delaware			
12. CITIZEN OF WHAT COUNTRY USA				13. FATHER'S NAME John H. Elliott				14. MOTHER'S MAIDEN NAME Ada Wright			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none				17. INFORMANT Mrs. L. H. Hall, Hebron, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchiectasis DUE TO Conditions, if any, which gave rise to immediate cause (b) Arterio-sclerotic cardio-vascular disease (c) Arterio-sclerotic cardio-vascular disease DUE TO cause last. (c) Arterio-sclerotic cardio-vascular disease INTERVAL BETWEEN ONSET AND DEATH Months Years											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) no											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)				20h. (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 4-24-61											
ACTUAL SIGNATURE Earl L. Royer, M.D.				EXAMINER'S NAME (Type) Earl L. Royer, M.D.				22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial			
22b. DATE THEREOF 4/27/61				22c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery				22d. LOCATION (City, town, or country) (State) Laurel, Del.			
23. FUNERAL DIRECTOR William J. Eskam, Jr.				ADDRESS Georgetown, Del.				24a. REC'D BY REGISTRAR MAY 1 '61			
24b. REGISTRAR'S SIGNATURE Arthur L. Kneass											

THE STATE

OF NEW YORK

IN SENATE

1

REPORT OF THE COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE
MAY 1, 1906

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4937

CERTIFICATE OF DEATH

Reg. Dist. No. 04925

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 15 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula Gen. Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mollie Middle C. Fontaine Last		4. DATE OF DEATH Month 4 Day 22 Year 19 61	
5. SEX F M	6. COLOR OR RACE AA	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/14/1923
9. AGE (In years last birthday) yrs. 37		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundress		10b. KIND OF BUSINESS OR INDUSTRY Laundry	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles H. Fontaine		14. MOTHER'S MAIDEN NAME Lilly Collier	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Address Box 132 Mrs. Lilly Collier Fontaine, Marion, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Chemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive C.V. Renal Disease (c) 20 yrs.		INTERVAL BETWEEN ONSET AND DEATH 20 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-12 , 19 56 , to 4-22 , 19 61 , that I last saw the deceased alive on 4-22 , 19 61 , and that death occurred at 3 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 4-22-61			
ACTUAL SIGNATURE Earl L. Royer M.D.			
PHYSICIAN'S NAME (Type) Earl L. Royer, M. D. 407 Camden Ave., Salisbury, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/26/61	
22c. NAME OF CEMETERY OR CREMATORY St. James Cem		22d. LOCATION (City, town, or county) (State) Nr. Manokin, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Thornton B. Jolley, Salisbury, Md		24a. REC'D BY REGISTRAR DATE APR 28 '61	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

1

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1934

(M)

Decedent's Name [Illegible]		Date of Death [Illegible]	
Place of Birth [Illegible]		Age at Death [Illegible]	
Sex [Illegible]		Race [Illegible]	
Occupation [Illegible]		Cause of Death [Illegible]	
Signature of Physician [Illegible]		Signature of Registrar [Illegible]	
Date of Signature [Illegible]		Place of Signature [Illegible]	

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4938

CERTIFICATE OF DEATH

Reg. Dist. No. 04926

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stockton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>23X-2</u>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Foreman</u> Last <u>Foreman</u>		4. DATE OF DEATH Month <u>4</u> Day <u>3</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 14, 1919</u>
9. AGE (In years last birthday) <u>42</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Foreman</u>		14. MOTHER'S MAIDEN NAME <u>Annie Taylor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Joseph Staten Pocomoke, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>592X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CHRONIC GLOMERULONEPHRITIS</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 28, 1961</u> , to <u>April 3, 1961</u> , that I last saw the deceased alive on <u>April 3, 1961</u> , and that death occurred at <u>9:00</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas C. Hill, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Pine Bluff Road</u> DATE SIGNED <u>4/5/61</u>	
PHYSICIAN'S NAME (Type) <u>Salisbury, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>4-8-61</u>	<u>St. Paul Cem.</u>	<u>Stockton, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, Va.</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>APR 11 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

CERTIFICATE OF DEATH

6038

Stockton
Maryland

No. 1
The above named person was born on Feb. 11, 1919 at
Maryland, U.S.A.

CHRONIC GLAUCOMA OF THE EYES
DIED AT

April 3, 1961
March 28, 1961

Dr. J. H. Hill
Five Bluff Road
Salisbury, Md.
4/2/61

Stockton, Md.
April 4, 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

4939

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04927

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quantico</u>			c. LENGTH OF STAY IN 1b <u>3 Yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quantico</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cherrywalk Rd.,</u>				d. STREET ADDRESS <u>Cherrywalk Rd.,</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>CORA</u> Middle <u>TAYLOR</u> Last <u>GILLIS</u>				4. DATE OF DEATH Month <u>4</u> Day <u>20</u> Year <u>1961</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-29-1871</u>		
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Washington Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Ann Ingersoll</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mrs. Marion C. Bailey, Same</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> <u>Arteriosclerotic Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Viral infection</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>		
21. I certify that (I) (this hospital) attended the deceased from <u>7/1</u> 19 <u>61</u> , to <u>death</u> 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>7/18</u> 19 <u>61</u> , and that death occurred on <u>4:AM</u> , from the causes and on the date stated above.								
22a. SIGNATURE <u>Ernest M. Larmore</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4-20-1961</u>		
22c. PHYSICIAN'S NAME (Type) <u>Dr. Ernest M. Larmore</u>				22d. ADDRESS <u>Grave St., Delmar, Delaware</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-22-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Siloam Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Siloam, Maryland</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co. Salisbury, Maryland</u>				25a. REC'D BY REGISTRAR <u>APR 25 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

14984

CERTIFICATE OF DEATH

1930

1



1



4940

CERTIFICATE OF DEATH

Reg. Dist. No. 04928

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>6 WEEKS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General</u>				d. STREET ADDRESS <u>2nd & Vine Sts.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>JUANITA</u>		First <u>V.</u> Middle <u>V.</u> Last <u>Givens</u>		4. DATE OF DEATH <u>APRIL</u>		Day <u>4</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 13, 1902</u>		9. AGE (In years lost birthday) <u>58</u> yrs.	IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN W. BUNDICK</u>				14. MOTHER'S MAIDEN NAME <u>VIRGINIA MASSEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-36-1442</u>		INFORMANT <u>ROBERT I. GIVENS, JR.</u> Address <u>Pocomoke City, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinomatosis</u> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Stomach</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4-5 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>NOV -</u> , 19 <u>60</u> , to <u>APRIL 4</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>April 4</u> , 19 <u>61</u> , and that death occurred at <u>4:40</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William H. Fisher</u>		ADDRESS (Street, city or town, state) <u>Salisbury Md.</u>		DATE SIGNED <u>4-8-61</u>			
PHYSICIAN'S NAME (Type) <u>WILLIAM H. FISHER, JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-6-61</u>		22c. NAME OF CEMETERY <u>BETHANY METHODIST</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke City MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Watson</u>		ADDRESS <u>Pocomoke City, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 10 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1960



[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a standard death certificate form with fields for personal information, cause of death, and medical history.]

[Faint text lines visible:]

NAME: _____

DATE OF BIRTH: _____

PLACE OF BIRTH: _____

DATE OF DEATH: _____

CAUSE OF DEATH: _____

[Additional faint text and lines follow, including what might be a signature area and a section for medical history.]

CERTIFICATE OF DEATH

Reg. Dist. No.

04929

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delisbury</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>		d. STREET ADDRESS <u>FERRY ST</u>	
3. NAME OF DECEASED (Type or print) <u>NORMAN LUTHER</u> First Middle Last		4. DATE OF DEATH <u>April 3, 1961</u> Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 9, 1906</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICIAN</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>GEORGE GOOTEE</u>		14. MOTHER'S MAIDEN NAME <u>SALLIE PHILLIPS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-034712</u>	
17. INFORMANT <u>MRS CAROLYN HURLEY</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Abdominal Carcinomatosis</u> 1530 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of cecum</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>September</u> , 19 <u>60</u> , to <u>April 4, 3, 1961</u> that I last saw the deceased alive on <u>April 4, 3, 1961</u> , and that death occurred at <u>11:45</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William H. Fisher Jr</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM H. FISHER JR</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL 6, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FIREMENS</u>		22d. LOCATION (City, town, or county) (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Smith Funeral Home, Sharptown, MD</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>APR 10 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

7

CERTIFICATE OF DEATH

Reg. Dist. No. 04930

4942

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>Bishop</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>23 X 2</u>	
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Mark</u> Last <u>Gray</u>		4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 20, 1894</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Timothy Hudson</u>		14. MOTHER'S MAIDEN NAME <u>Charlott Lynch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>XX</u>		16. SOCIAL SECURITY NO. <u>XX</u>	
17. INFORMANT <u>Mitchell Gray Bishop, Md.</u>		Address <u>Mitchell Gray Bishop, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Metastasis suspect</u> <u>162.01</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchogenic Carcinoma suspect.</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>1 April</u> , 19 <u>61</u> , to <u>8 April</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>8 April</u> , 19 <u>61</u> , and that death occurred at <u>5:45 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Bishopville, Md.</u> DATE SIGNED <u> </u>			
ACTUAL SIGNATURE <u>Joseph C. Fitzgerald</u>		M.D. <u> </u>	
PHYSICIAN'S NAME (Type) <u> </u>		<u> </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/11/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>I. O. O. F</u>	22d. LOCATION (City, town, or county) (State) <u>Bishopville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Peter Whaley Seligson, Sel.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 12 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>		<u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No. 04931

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 4 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springhill Sanitarium		d. STREET ADDRESS -----	
3. NAME OF DECEASED (Type or print) Verina First Hackett Last		4. DATE OF DEATH Month April Day 23 , Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 29, 1863
9. AGE (In years last birthday) 98 yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Thomas Rasin	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) No (If yes, give war or dates of service) _____	
16. SOCIAL SECURITY NO. None		17. INFORMANT Address Sanitarium Records Salisbury, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 450.1 DUE TO Arterio-sclerotic gangrene right leg Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized arterio-sclerosis DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year 19 o. m. _____ p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from 1957 to 4-23 , 19 61 , that I last saw the deceased alive on 4-21 , 19 61 , and that death occurred at 12:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Philip A. Insley M.D.		ADDRESS (Street, city or town, state) Salisbury Md DATE SIGNED 4-24-61	
PHYSICIAN'S NAME (Type) Philip A. Insley M. D.		116 East Main St., Salisbury, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/25/61	22c. NAME OF CEMETERY OR CREMATORY Still Pond Cemetery	22d. LOCATION (City, town, or county) (State) Still Pond, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy		ADDRESS Still Pond, Md.	24c. REC'D BY REGISTRAR DATE APR 26 '61
24b. REGISTRAR'S SIGNATURE Arthur L. Kneel			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
4944 CERTIFICATE OF DEATH 04932											
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Worcester					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury						c. LENGTH OF STAY IN lb 69 days					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Deer's Head State Hospital						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whaleyville					
d. STREET ADDRESS 23X-2						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Laura Middle D. Last Hamblin						4. DATE OF DEATH Month April Day 26 Year 1961					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 30, 1876		9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lemuel Davis						14. MOTHER'S MAIDEN NAME (UNKNOWN)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) XX XX				16. SOCIAL SECURITY NO. xxx		17. INFORMANT Address Mrs. Louise Campbell Selbyville, Del.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis, generalized (c) Arteriosclerosis, generalized DUE TO (e), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH Years Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from February 16 1961 , to April 26 1961 , that (I) (we) last saw the deceased alive on April 26 1961 , and that death occurred at M , from the causes and on the date stated above.											
22a. SIGNATURE L. V. Maldve, M. D.						22b. DATE SIGNED 4/26/61		22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.			
22d. ADDRESS Deer's Head Hospital; Salisbury, Md.				22e. REC'D BY REGISTRAR DATE MAY 1 '61							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4/29/61		23c. NAME OF CEMETERY OR CREMATORY Dale		23d. LOCATION (City, town or county) Whaleyville, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley Selbyville Del.											

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CERTIFICATE OF DEATH

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04932

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u>		b. COUNTY <u>WICOMICO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POWELLVILLE</u>		c. LENGTH OF STAY IN 1b <u>30 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POWELLVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CLARA</u>		First <u>MARTLE</u>		Middle <u>HAMMOND</u>		Last <u>1961</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 21, 1910</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>WHALEYVILLE, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE T. DONOWAY</u>				14. MOTHER'S MAIDEN NAME <u>FLORIDA FARLOW</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>N/A</u>		17. INFORMANT <u>MR. LEWIS J. HAMMOND, POWELLVILLE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Obesity</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Willards Maryland</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1958</u> to <u>day of death</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Frank Lewis</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Frank Lewis</u>				22d. ADDRESS <u>Willards Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5/2/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Pleasant</u>		23d. LOCATION (City, town, or county) (State) <u>POWELLVILLE (RFD) MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burboye</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 8 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

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CHIEF P. H. WILSON

MADE IN U.S.A.

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
4946									
CERTIFICATE OF DEATH									
Reg. Dist. No. 04934									
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico				
c. LENGTH OF STAY IN 1b					5. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL Hospital					d. STREET ADDRESS 702 Baker St			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last HARE					4. DATE OF DEATH Month April Day 28 Year 1961				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-28-61		9. AGE (In years last birthday) 11	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Salisbury, Md			12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME John H. Hare					14. MOTHER'S MAIDEN NAME PATRICIA ANN JONES - 702 Baker St Salisbury, Md				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. John H. Hare (Father) 702 Baker St Salisbury, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 773.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 Prematurity DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 11 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Apr 27 , 1961, to Apr 28 , 1961, that I last saw the deceased alive on Apr 28 , 1961, and that death occurred at 7:45 M, from the causes and on the date stated above.									
ACTUAL SIGNATURE B. Frank Giganti					ADDRESS (Street, city or town, state) Medical Center Salisbury				
PHYSICIAN'S NAME (Type) B. FRANK GIGANTI, M.D.					DATE SIGNED 4/28/61				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 29, 1961		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery			22d. LOCATION (City, town, or county) (State) Salisbury, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR MAY 3 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR AT-ENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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4947

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04935

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HERMAN</u> First <u>Lloyd</u> Middle <u>Hearn</u> Last				4. DATE OF DEATH <u>April</u> Month <u>3</u> Day <u>19</u> Year <u>61</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 27, 1877</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>8</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Wicomico Co. Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>							
13. FATHER'S NAME <u>Elijah Sharp Hearn</u>				14. MOTHER'S MAIDEN NAME <u>Mellissa White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Mr. Everett E. Hearn (Son)</u> Address <u>430 W. College Ave Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease with</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Insufficiency and</u> DUE TO (c) <u>Nephrosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gastro-Intestinal Hemorrhage - cause Undetermined</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>N/A</u> 19 p. m. <u>N/A</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>				20f. (City or town) <u>N/A</u> (County) (State)			
21. I certify that I attended the deceased from <u>March 21, 1961</u> to <u>April 3, 1961</u> , that I last saw the deceased alive on <u>April 3, 1961</u> , and that death occurred at <u>9:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas C. Hill Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Pine Bluff Road Salisbury, Md.</u> DATE SIGNED <u>4/3/61</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Thomas C. Hill Jr</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 5, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY, MARYLAND</u>				24a. REC'D BY REGISTRAR <u>PR 5 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krause</u>	

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CERTIFICATE OF DEATH

1964

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1. Name of deceased: John Doe

2. Sex: Male

3. Race: White

4. Date of birth: 1/1/1900

5. Date of death: 12/31/1964

6. Place of death: 123 Main St, New York, NY

7. Cause of death: Heart Disease

8. Manner of death: Natural

9. Signature of physician: Dr. J. Smith

10. Signature of registrar: John Doe

DEPT. OF HEALTH
NORTH DAKOTA

1918

MARITAL AND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

IN 1918

County of _____

State of _____

City of _____

Wisconsin

Decedent

Deceased

Age _____

Sex _____

Color _____

Married _____

Occupation _____

Signature of Medical Examiner

Signature of Coroner

Witness

Signature of Medical Examiner

Signature of Coroner

Signature of Medical Examiner

Signature of Coroner

Signature of Medical Examiner

1918

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4943

CERTIFICATE OF DEATH

Reg. Dist. No. 04937

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware b. COUNTY Sussex	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 4 hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WALTER Middle R. Last HENRY		4. DATE OF DEATH Month 4 Day 21 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 14, 1884
9. AGE (In years lost birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 7 Days 7 Hours 7 Min.	11. IF UNDER 24 HRS. Months 7 Days 7 Hours 7 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Conductor		10b. KIND OF BUSINESS OR INDUSTRY RR	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN F. HENRY		14. MOTHER'S MAIDEN NAME IDA COLLINS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. INFORMANT Address STELLA HENRY, 7th St., Laurel Delaware	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO (b) 420.0 DUE TO (c) Arteriosclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH Centennium			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NO			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 4:21		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-21-1961 to 4-21-1961 , that I last saw the deceased alive on 4-21-1961 , and that death occurred at 5:35 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE William S. Ellison		ADDRESS (Street, city or town, state) Federalburg, Md DATE SIGNED 4-21-61	
PHYSICIAN'S NAME (Type) William S. Ellison			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/24/61	
22c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery		22d. LOCATION (City, town, or county) (State) Laurel, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE Harry Williamson ADDRESS Federalburg, Maryland		24a. REC'D BY REGISTRAR APR 26 '61 DATE APR 26 '61	
24b. REGISTRAR'S SIGNATURE William S. Ellison			

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CERTIFICATE OF DEATH

1963

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4950

04938

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland		c. LENGTH OF STAY IN 1b 11mo. 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Deer's Head State Hospital		e. STREET ADDRESS Sharptown, Md.	
3. NAME OF DECEASED (Type or print) William Harrison Hopkins		4. DATE OF DEATH Month April Day 2 Year 19 61	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1903
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months 57 Days 19 Hours 61 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (County & State, or foreign country) Sharptown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leonard Hopkins		14. MOTHER'S MAIDEN NAME Martha Goslee	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 214-12-6578	
17. INFORMANT Mrs. Cordie C. Hopkins, Sharptown, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent cerebral thrombosis 332X DUE TO Arteriosclerosis general Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. } DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 25, 19 60 to April 2, 19 61 , that (I) (we) last saw the deceased alive on April 2, 19 61 , and that death occurred at 2:10AM from the causes and on the date stated above.			
22a. SIGNATURE V. Juerman M.D.		22b. DATE April 2, 1961	
22c. PHYSICIAN'S NAME (Type) V. Juerman, M.D.		22d. ADDRESS Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF April 6, 1961	23c. NAME OF CEMETERY OR CREMATORY Zion Church Cemetery	23d. LOCATION (City, town or county) (State) Near Sharptown, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE J. J. Hampton Inc. Federalsburg, Md.		25a. REC'D BY REGISTRAR DATE APR 10 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

6216

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/5B

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4951

CERTIFICATE OF DEATH

Reg. Dist. No. 04939

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHALEYVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>		d. STREET ADDRESS <u>23X-9</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>URIAH A. HUDSON</u>		4. DATE OF DEATH Month Day Year <u>April 30 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 17, 1877</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LAYBURN HUDSON</u>		14. MOTHER'S MAIDEN NAME <u>MARY ELIZABETH MUMFORD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mr. ARTHUR HUDSON</u>		Address <u>BISHOP, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/29</u> , 19 <u>61</u> , to <u>4/30</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>4/29</u> , 19 <u>61</u> , and that death occurred at <u>10:00</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas C. Hill, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Pine Bluff Road</u> DATE SIGNED <u>4/30/61</u>	
PHYSICIAN'S NAME (Type) <u>Salisbury Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/3/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>NEW HOPE</u>		22d. LOCATION (City, town, or county) (State) <u>WILLARDS MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u> ADDRESS <u>Bethesda Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 5 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krasner</u>	

CERTIFICATE OF DEATH

1907

(M)

1. Name of deceased: *John J. ...*
2. Age: *...*
3. Sex: *...*
4. Date of death: *...*
5. Place of death: *...*
6. Cause of death: *...*
7. Signature of physician: *...*
8. Signature of registrar: *...*
9. Date of registration: *...*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

4952

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04940

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b Since 4/15/59			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pine Bluff State Hospital				d. STREET ADDRESS 09x			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Marion Middle Virginia Last Jackson		4. DATE OF DEATH Month April Day 29 Year 1961					
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/12/1916	9. AGE (In years lost birthday) 44 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Jackson				14. MOTHER'S MAIDEN NAME Mary Elizabeth Thompson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-07-7881		17. INFORMANT Address Records of Pine Bluff State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Amyloidosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Emyema DUE TO (c) Pulmonary tuberculosis						INTERVAL BETWEEN ONSET AND DEATH 3 yrs 5 yrs 22 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 15, 1959 , to April 29, 1961 , that (I) (we) last saw the deceased alive on April 28, 1961 , and that death occurred at 2:06 A. M., from the causes and on the date stated above.							
22a. SIGNATURE E. P. Ritchings				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/29/61	
22c. PHYSICIAN'S NAME (Type) E. P. Ritchings, M.D.				22d. ADDRESS Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 2, 1961		23c. NAME OF CEMETERY OR CREMATORY Petersburg Cemetery		23d. LOCATION (City, town, or county) (State) Near Hurlock, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J. J. Trampton and Son, Federalburg, Maryland				25a. REC'D BY REGISTRAR DATE MAY 1 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Knaas	

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DEPARTMENT OF HEALTH
CENTRAL OFFICE OF DEATH

NAME

AGE

SEX

DATE

TIME

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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4953

4953 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04941

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b Since 3/30/61		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pine Bluff State Hospital			d. STREET ADDRESS --		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Stephen Middle William Last Jackson, Jr.			4. DATE OF DEATH Month April Day 9 Year 19 61		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Jan. 5, 1887		9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sawyer		10b. KIND OF BUSINESS OR INDUSTRY Timber		11. BIRTHPLACE (State or foreign country) Newark, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Stephen William Jackson, Sr.		14. MOTHER'S MAIDEN NAME Laura Littleton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-12-1930		17. INFORMANT Records of Pine Bluff State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Tuberculosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from March 30, 1961 , to April 9, 1961 , that (I) (we) lost saw the deceased alive on April 9, 1961 , and that death occurred 2:40 P M, from the causes and on the date stated above.					
22a. SIGNATURE E. P. Ritchings		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/10/61	
22c. PHYSICIAN'S NAME (Type) E. P. Ritchings, M.D.		22d. ADDRESS Pine Bluff State Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-12-61		23c. NAME OF CEMETERY First Baptist	
23d. LOCATION (City, town, or county) (State) Girdletree, Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE Robert H. Watson		ADDRESS Pocomoke City, Md.		25a. REC'D BY REGISTRAR DATE APR 12 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

CERTIFICATE OF DEATH

1902

Place of Birth

Place of Death

Time of Death

Signature

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death.

VS. A15ME
5M 7/59

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<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH </div>													
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 317 Poplar Hill Ave. d. STREET ADDRESS Salisbury e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) William E. Jackson First Middle Last 5. SEX M 6. COLOR OR RACE C 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 10/26/1900 9. AGE (In years, last birthday) 60 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.						4. DATE OF DEATH 4-14-61 Month Day Year 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 10b. KIND OF BUSINESS OR INDUSTRY Oil 11. BIRTHPLACE (State or foreign country) Virginia 12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Cornelius Jackson 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year of service)						14. MOTHER'S MAIDEN NAME Jane ? 16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Viola Jackson, 317 Poplar Hill Ave., Salisbury, Md							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Cerebral Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH year	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)													
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>													
ACTUAL SIGNATURE Earl L. Royer, M.D. M.D. EXAMINER'S NAME (Type) Earl L. Royer, M.D. 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 4/19/1960 22c. NAME OF CEMETERY OR CREMATORY Green Acre Cem 22d. LOCATION (City, town, or country) (State) Salisbury, Md													
23. FUNERAL DIRECTOR Thornton B. Jolley, Salisbury, Md 24a. REC'D BY REGISTRAR APR 20 '61 24b. REGISTRAR'S SIGNATURE Curtis S. Hines													

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TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4955

04943

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN lb <u>23 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Deer's Head State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> d. STREET ADDRESS <u>130 Washington Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>Kiah</u> Last <u>Johnson</u>				4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>19 61</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 26, 1881</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Madison, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>William Mister</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Cannady</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unk.</u>				16. SOCIAL SECURITY NO. <u>Unk.</u>			
17. INFORMANT <u>Hospital Records -- Salisbury, Maryland</u>				Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis -</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>10 yrs.</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>4/5/61</u> , 19....., to <u>4/28/61</u> , 19....., that (I) (we) last saw the deceased alive on <u>4/28/61</u> , 19....., and that death occurred at <u>8:PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Lee L. Lawry</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>April 29, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lee L. Lawry, M.D.</u>				22d. ADDRESS <u>Salisbury, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/2/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		23d. LOCATION (City, town or county) <u>Cambridge, Md.</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Harold H. Sellars Jr.</u>				ADDRESS <u>Cambridge, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 3 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>			

MEDICAL CERTIFICATION

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Cambridge, No.

Cambridge, No.

Cambridge, No.

Cambridge, No.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

4956
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04944

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 198-2	
3. NAME OF DECEASED (Type or print) Robert Lee Larmore		4. DATE OF DEATH 4-19-61	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 21, 1900
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus Driver		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles Larmore		14. MOTHER'S MAIDEN NAME Ruth Hickman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) I		16. SOCIAL SECURITY NO. Eva Larmore	
17. INFORMANT Princess Anne, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 4-22-61			
ACTUAL SIGNATURE Earl L. Royer, M.D.		EXAMINER'S NAME (Type) 407 Camden Ave., Salisbury, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 4/22/61	22c. NAME OF CEMETERY OR CREMATORY Rehobeth Presbyterian	22d. LOCATION (City, town, or country) (State) Rehobeth, Md.
23. FUNERAL DIRECTOR James L. Linn		24. REC'D BY REGISTRAR APR 27 '61	
ADDRESS Princess Anne, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Harris	

IN THE COURT OF THE DISTRICT OF COLUMBIA

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Income Tax

Self-employment

Benjamin Franklin Hospital

Home

John A. Johnson

1-1-61

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1-1-61

2.3

General

W. J. Johnson

1-1-61

Self-employment

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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4957
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
04945

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury(Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury(Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 3		d. STREET ADDRESS R.D.# 3	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELMER Middle THOMAS Last LEONARD		4. DATE OF DEATH Month APRIL Day 10th Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 24, 1898
9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 0 Days 16	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming R.D.#3 Salisbury, Md.	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Harry Leonard		14. MOTHER'S MAIDEN NAME Gattie E. Parker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mrs. Martha E. Leonard (Wife) R.D.# 3 Salisbury, Maryland		Address R.D.# 3	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Healed pulmonary T.B.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour o. m. N/A p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work 	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) (County) (State) N/A	
21. I certify that (I) (this hospital) attended the deceased from 1955 to day of death , that (I) (we) last saw the deceased alive on April 9 19 61 , and that death occurred at 10 AM , from the causes and on the date stated above.			
22a. SIGNATURE Frank Lewis		22b. DATE SIGNED April 11 / 1961	
22c. PHYSICIAN'S NAME (Type) Dr. Frank R. Lewis		22d. ADDRESS Willards, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 12, 1961	
23c. NAME OF CEMETERY OR CREMATORY Wicomico Mem. Park		23d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		25a. REC'D BY REGISTRAR APR 14 '61	
ADDRESS SALISBURY MARYLAND		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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CHIEF CLERK

201-101-101

1953

CERTIFICATE OF DEATH

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VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

100-100000



CERTIFICATE OF DEATH

Reg. Dist. No.

04947

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>R. 7, 1.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>IRVING</u> Middle <u>MORRIS</u> Last <u>MORRIS</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>10</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 6, 1905</u>
9. AGE (In years lost birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months <u>55</u> Days <u>55</u> Hours <u>55</u> Min. <u>55</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FACTORY-WORK</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EDWARD MORRIS</u>		14. MOTHER'S MAIDEN NAME <u>MARY GUNTER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Isaac Gunter - Pocomoke, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X</u> DUE TO <u>Bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>491X</u> DUE TO <u>491X</u> (c) <u>491X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9 Apr</u> , 19 <u>61</u> , to <u>10 Apr</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>10 Apr</u> , 19 <u>61</u> , and that death occurred at <u>12:30</u> A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-15-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Tinsley Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - new church, Va.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 17 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

CERTIFICATE OF DEATH

1953

(M)

DATE

TIME

PLACE

Cause

Age

Sex

Color

Height

Weight

Build

Complexion

Scars

Other

Signature

Witness

Registrar

Official

Signature

Witness

Registrar

Official

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Registrar

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Signature

Witness

Registrar

Official

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ocean City	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General		d. STREET ADDRESS 409 Baltimore Ave.	
3. NAME OF DECEASED (Type or print) First Arthur Middle WELLINGTON Last Plummer Jr.		4. DATE OF DEATH Month 4 Day 9 Year 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 9, 1925
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trooper 1 c. Maryland State Police		9. AGE (In years last birthday) 36 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) U S A	
13. FATHER'S NAME Mr. Arthur W. Plummer, Sr.		14. MOTHER'S MAIDEN NAME MARGARET A. McISACC	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW II	
17. INFORMANT Mrs. Polly D. Plummer - SAME		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of skull DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Injured in plane that crashed on take off.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 6:30 P.M. 4-9-1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Assateague Island	
20f. (City or town) Assateague Island		20g. (County) Va.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) 407 Camden Ave. Salisbury, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/13/1961	
22c. NAME OF CEMETERY OR CREMATORY EVERGREEN CEMETERY		22d. LOCATION (City, town, or county) BEELIN, MARYLAND	
23. FUNERAL DIRECTOR Hill and Johnson		24a. REC'D BY REGISTRAR APR 14 '61	
ADDRESS Salisbury, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

Revised this 2

100 STATE
MAINE DEPT.

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Worcester

Bellevue

Bellevue Hospital

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Bellevue Hospital

Bellevue Hospital

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Bellevue Hospital

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 22 hours after death.

MEDICAL CERTIFICATION

<div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>4961</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div> <div> <div>04949</div> <div>23X-2</div> </div> </div> <div> <div> <div>1</div> <div>PLACE OF DEATH</div> <div>a. COUNTY</div> <div>Wicomico</div> <div>MARYLAND</div> </div> <div> <div>2</div> <div>USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</div> <div>a. STATE</div> <div>Maryland</div> <div>b. COUNTY</div> <div>Worcester</div> </div> </div> <div> <div> <div>3</div> <div>NAME OF DECEASED (Type or print)</div> <div>CHARLES Theodore</div> <div>Purnell</div> </div> <div> <div>4</div> <div>DATE OF DEATH</div> <div>4-9-61</div> <div>19</div> </div> </div> <div> <div> <div>5</div> <div>SEX</div> <div>M</div> <div>6</div> <div>COLOR OR RACE</div> <div>W</div> </div> <div> <div>7</div> <div>MARRIED</div> <div>NEVER MARRIED</div> <div>8</div> <div>DATE OF BIRTH</div> <div>Nov. 17, 1926</div> </div> </div> <div> <div> <div>9</div> <div>AGE (In years last birthday)</div> <div>34</div> <div>10</div> <div>CITIZEN OF WHAT COUNTRY?</div> <div>U.S.A.</div> </div> <div> <div>11</div> <div>BIRTHPLACE (State or foreign country)</div> <div>Ocean City MD</div> </div> </div> <div> <div> <div>12</div> <div>USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>Vice-President</div> <div>13</div> <div>FATHER'S NAME</div> <div>Dr. C. W. Purnell</div> </div> <div> <div>14</div> <div>KIND OF BUSINESS OR INDUSTRY</div> <div>Atlantic Hotel</div> </div> </div> <div> <div> <div>15</div> <div>WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)</div> <div>YES</div> <div>WORLD WAR 2</div> <div>16</div> <div>SOCIAL SECURITY NO.</div> <div>17</div> <div>INFORMANT</div> <div>MR. C.T. Purnell, Ocean City MD</div> </div> <div> <div>18</div> <div>CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div> <div> <div>18a</div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a)</div> <div>866X</div> <div>Fracture of skull</div> </div> <div> <div>18b</div> <div>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</div> <div>18c</div> <div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</div> </div> </div> <div> <div>19</div> <div>WAS AUTOPSY PERFORMED?</div> <div>YES</div> <div>NO</div> </div> </div> </div> <div> <div> <div>20a</div> <div>EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</div> <div>20b</div> <div>DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</div> <div>Injured when plane crashed in take off.</div> </div> <div> <div>20c</div> <div>TIME OF INJURY</div> <div>6:30 P.M.</div> <div>4-9-61</div> <div>20d</div> <div>INJURY OCCURRED</div> <div>While at work</div> <div>20e</div> <div>PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div> <div>Assateague Island</div> </div> </div> <div> <div> <div>21</div> <div>I certify that I took charge of the remains described above, held an Autopsy</div> <div>Inspection</div> <div>Inquiry</div> <div>and in my opinion death resulted from:</div> <div>Natural causes</div> <div>Accident</div> <div>Suicide</div> <div>Homicide</div> <div>Undetermined manner</div> </div> <div> <div>22a</div> <div>BURIAL, CREMATION, REMOVAL (Specify)</div> <div>BURIAL</div> <div>22b</div> <div>DATE THEREOF</div> <div>4/12/61</div> <div>22c</div> <div>NAME OF CEMETERY OR CREMATORY</div> <div>EVERGREEN</div> </div> </div> <div> <div> <div>23</div> <div>FUNERAL DIRECTOR</div> <div>Anna R Burbage</div> <div>Burbage Funeral Home, Berlin, Md.</div> </div> <div> <div>24a</div> <div>REC'D BY REGISTRAR</div> <div>APR 14 '61</div> <div>24b</div> <div>REGISTRAR'S SIGNATURE</div> <div>Arthur S. Hines</div> </div> </div>											
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4962.

CERTIFICATE OF DEATH

Reg. Dist. No. 44950

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Md.</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>		d. STREET ADDRESS <u>Waterview Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY ELIZABETH Purnell</u>		4. DATE OF DEATH Month Day Year <u>April 27 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 10, 1919</u>
9. AGE (In years last birthday) <u>41</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Handy Cox</u>		14. MOTHER'S MAIDEN NAME <u>Delcie Bounds</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>George T. Purnell Jr</u>	
17. ADDRESS <u>Laurel Del</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden severe, gastro-intestinal</u> 157X DUE TO <u>hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Secondary carcinoma of stomach</u> DUE TO <u>Cancer of the Pancreas (Very advanced)</u> (c) <u>Cancer of the Pancreas (Very advanced)</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>11:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Carrie Hearn</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury Md</u>	
DATE SIGNED <u>4/28/61</u>			
PHYSICIAN'S NAME (Type) <u>CARRIE HEARN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/30/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ODD Fellows Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel Del.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William E. Shanks</u>		ADDRESS <u>Georgetown, Del.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAY 2 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1918

10-10-18

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4963

CERTIFICATE OF DEATH

Reg. Dist. No. 04951

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Oren</u> First <u>Edwin</u> Middle <u>Richardson Jr.</u> Last		4. DATE OF DEATH Month <u>4</u> Day <u>27</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 26, 1943</u>
9. AGE (In years last birthday) <u>17</u> yrs.		IF UNDER 1 YEAR Months <u>17</u> Days <u>17</u> Hours <u>17</u> Min. <u>17</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Child</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Oren E. Richardson Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Ann Parsons</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>XX</u>		16. SOCIAL SECURITY NO. <u>XXXXX</u>	
17. INFORMANT <u>Oren Richardson</u>		Address <u>Willards, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rheumatic Heart Disease</u> <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-23</u> , 19 <u>61</u> , to <u>4-27</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>4-27</u> , 19 <u>61</u> , and that death occurred at <u>9:20 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William R. Goss</u>		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>4-28-61</u>	
PHYSICIAN'S NAME (Type) _____		_____	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/30/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Pittsville</u>	22d. LOCATION (City, town, or county) (State) <u>Pittsville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Peter Whaley</u>		ADDRESS <u>Salisbury, Md.</u>	
4a. REC'D BY REGISTRAR <u>MAY 1 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1967

M

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible] DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible] OCCUPATION: [illegible] CAUSE OF DEATH: [illegible]

DATE OF DEATH: [illegible] TIME OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DECEASED'S SIGNATURE: [illegible] WITNESSES' SIGNATURES: [illegible]

DECEASED'S ADDRESS: [illegible] CITY: [illegible] STATE: [illegible] ZIP: [illegible]

DECEASED'S SOCIAL SECURITY NUMBER: [illegible] DECEASED'S MARITAL STATUS: [illegible]

DECEASED'S RACE: [illegible] DECEASED'S RELIGION: [illegible] DECEASED'S ETHNICITY: [illegible]

DECEASED'S EDUCATION: [illegible] DECEASED'S OCCUPATION: [illegible] DECEASED'S EMPLOYER: [illegible]

DECEASED'S DATE OF BIRTH: [illegible] DECEASED'S TIME OF BIRTH: [illegible] DECEASED'S PLACE OF BIRTH: [illegible]

DECEASED'S DATE OF DEATH: [illegible] DECEASED'S TIME OF DEATH: [illegible] DECEASED'S PLACE OF DEATH: [illegible]

DECEASED'S DATE OF BURIAL: [illegible] DECEASED'S TIME OF BURIAL: [illegible] DECEASED'S PLACE OF BURIAL: [illegible]

DECEASED'S DATE OF CREMATION: [illegible] DECEASED'S TIME OF CREMATION: [illegible] DECEASED'S PLACE OF CREMATION: [illegible]

DECEASED'S DATE OF INTERMENT: [illegible] DECEASED'S TIME OF INTERMENT: [illegible] DECEASED'S PLACE OF INTERMENT: [illegible]

DECEASED'S DATE OF REINTERMENT: [illegible] DECEASED'S TIME OF REINTERMENT: [illegible] DECEASED'S PLACE OF REINTERMENT: [illegible]

DECEASED'S DATE OF REINTERMENT: [illegible] DECEASED'S TIME OF REINTERMENT: [illegible] DECEASED'S PLACE OF REINTERMENT: [illegible]

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DECEASED'S DATE OF REINTERMENT: [illegible] DECEASED'S TIME OF REINTERMENT: [illegible] DECEASED'S PLACE OF REINTERMENT: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04952

4964

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 17 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Deer's Head State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 321 N. Division Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lillian Middle Dorman Last Sharpley				4. DATE OF DEATH Month April Day 20 Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 6, 1870	
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Levin Richard Dorman				14. MOTHER'S MAIDEN NAME Rachel Waller			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) None				16. SOCIAL SECURITY NO. None			
17. INFORMANT Richard D. LeViness, Same				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Retroperitoneal tumor DUE TO Condition, if any, which gave rise to immediate cause (b) 211 X (a), stating the underlying cause last. } DUE TO (c) Bilateral bronchopneumonia						INTERVAL BETWEEN ONSET AND DEATH Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 3, 1961 to April 20, 1961 , that (I) (we) last saw the deceased alive on April 20, 1961 , and that death occurred at 6:22 P.M. from the causes and on the date stated above.							
22a. SIGNATURE L. V. Maldve, M. D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4/21/61	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS Deer's Head State Hospital; Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-22-1961		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City, town or county) (State) Salisbury, Maryland	
24 FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland				25a. REC'D BY REGISTRAR APR 25 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
4965
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
04953

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN lb 3 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALICE PARKER SHOCKLEY		4. DATE OF DEATH Month 4 Day 25 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 5, 1881
9. AGE (In years last birthday) yrs. 79		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		12. KIND OF BUSINESS OR INDUSTRY Own Home	
13. BIRTHPLACE (State or foreign country) Maryland		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME J. Milton Parker		16. MOTHER'S MAIDEN NAME Rosanna Fooks	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		18. SOCIAL SECURITY NO. None	
19. INFORMANT Mr. Everett T. Shockley, Salisbury, Maryland		Address	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage Spontaneous DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive C.V. Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 days years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-23 19 61 , to 4-25 19 61 , that (I) (we) last saw the deceased alive on 4-25 19 61 , and that death occurred at 8:20 P.M., from the causes and on the date stated above.			
22a. SIGNATURE Earl L. Royer		22b. DATE SIGNED 4-28-61	
22c. PHYSICIAN'S NAME (Type) Dr. Earl L. Royer		22d. ADDRESS Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-28-61	
23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland		25a. REC'D BY REGISTRAR DATE MAY 2 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

CERTIFICATE OF DEATH

1922

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Reg. Dist. No. 04954

2082182XV4

VS A15 (4)
ISM 9/58

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

CENTRAL AIR OF DEATH

1000

Assembly

Assembly

BABY

None

None

None

None

None

10/10/12

10/10/12

None

None

None

None

10/10/12

None

None

None

None

None

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4967

CERTIFICATE OF DEATH

Reg. Dist. No. 04955

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Somerset Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL Hospital</u>		d. STREET ADDRESS <u>19x2</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harriet M. SPIVA</u>		4. DATE OF DEATH Month Day Year <u>April 11 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 7 1892</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Rev. Dr. Clive Murphy</u>		14. MOTHER'S MARDEN NAME <u>Sarah Daniel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> <u>4-20-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 58</u> to <u>April 11 1961</u> , that I last saw the deceased alive on <u>April 11 1961</u> and that death occurred at <u>10:15 AM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David J. Eilman</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury Md</u> DATE SIGNED <u>4/11/61</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-13-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Andrew's Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Somerset Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin R. Wilson R. Amey</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>APR 17 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

John James Jones

John James Jones

John James Jones

John James Jones

John James Jones

John James Jones

John James Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4968

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04956

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar				c. LENGTH OF STAY IN 1b 20 yrs				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 404 State Street				d. STREET ADDRESS 404 State Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last HERMAN LAWRENCE STERLING				4. DATE OF DEATH Month Day Year April 20 1961									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-1, 1884		9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Furniture		11. BIRTHPLACE (State or foreign country) Crisfield, Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Hiram Sterling				14. MOTHER'S MAIDEN NAME Emma Stevens									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 218-16-8520		17. INFORMANT Address Virginia Sterling, Delmar, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420-1 Coronary artery occlusion DUE TO Coronary arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2 DUE TO (c) 1										INTERVAL BETWEEN ONSET AND DEATH 4 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Intestinal obstruction - following reduction of incarcerated hernia												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) night inguinal hernia									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 4-19 19 61 , to 4-20 19 61 , that (I) (we) last saw the deceased alive on 4-19 19 61 , and that death occurred at 7:30 M, from the causes and on the date stated above.													
22a. SIGNATURE H. S. Oiler						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-21-61					
22c. PHYSICIAN'S NAME (Type) Dr. L. V. Sohler						22d. ADDRESS Delmar, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4-22-61		23c. NAME OF CEMETERY OR CREMATORY Crisfield		23d. LOCATION (City, town, or county) (State) Crisfield, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE W-S. Marul Co - Delmar, Del						ADDRESS Delmar, Md.		25a. REC'D BY REGISTRAR DATE APR 25 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

AP

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T

Handwritten notes and signatures, including the name "W. J. [illegible]" and various illegible scribbles.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4969

CERTIFICATE OF DEATH

Reg. Dist. No. 04957

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Princess Anne General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Nathaniel C Taylor</u>				4. DATE OF DEATH Month Day Year <u>April 25 1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 23 1961</u>	9. AGE (In years last birthday) yrs. <u>46</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min. <u>46 30</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nathaniel C. Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Rosa Ford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT <u>Nathaniel C. Taylor, Princess Anne Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity (Birth wt. 1150 gms.)</u> DUE TO (c) <u>approx 46 hrs.</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 23 1961</u> , to <u>April 25 1961</u> , that I last saw the deceased alive on <u>April 25 1961</u> , and that death occurred at <u>7:40</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Alfred C Kolls</u> M.D.				ADDRESS (Street, city or town, state) <u>Medical Center Salisbury Maryland</u>		DATE SIGNED <u>4/25/61</u>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/25/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GREEN ACRE Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thornton B. Jolley</u> ADDRESS <u>Salisbury, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 28 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Reed</u>	

2082291XVI

CERTIFICATE OF DEATH

NAME

DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
DISEASE
AGE
SEX
MARRIAGE
OCCUPATION
EDUCATION
RELIGION
BIRTH
DEATH

Attest

Signature of Registrar

1916

APPROVED AND FORWARDED
Signature of Registrar
Signature of Medical Officer
Signature of Coroner
Signature of Minister of Health
Signature of Registrar

1 18 4970 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

Reg. Dist. No. 04958

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>219 MONTICELLO ST. APT. A</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRENCH Woodville Thompson</u>		4. DATE OF DEATH Month Day Year <u>April 25 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 16, 1876</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED PROFESSOR COLLEGE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ARKANSAS</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WOODVILLE THOMPSON</u>		14. MOTHER'S MAIDEN NAME <u>SARAH MC GHEE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>MRS. M.T. HICKMAN, PAINTER, VA.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Acute Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u>Arteriosclerotic Heart Disease</u> (c) <u>3 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/27, 1959</u> to <u>4/25, 1961</u> , that I last saw the deceased alive on <u>4/25, 1961</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Rufus S. Gardner, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>PINEBLUFF Rd, Salisbury, Md.</u> DATE SIGNED <u>4/25/61</u>	
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER, JR.</u>		<u>SALISBURY, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4-28-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ROSEWOOD CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>LENISBURG, W. VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Williams</u> ADDRESS <u>Oranock, Va.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 28 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>C. L. Kneass</u>	

(M)

(I)

CERTIFICATE OF DEATH

WOODVILLE TEMPLETON

28444 No 64 EE

Remains were taken to

Not a date to be put in 1972

Edmund Woodville Templeton

born in Great Britain

28444 No 64 EE

28444 No 64 EE

28444 No 64 EE

CERTIFICATE OF DEATH

Reg. Dist. No. 04959

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>		d. STREET ADDRESS <u>23X-2</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>Todd</u> Last <u>Todd</u>		4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 1, 1961</u>
9. AGE (In years last birthday) yrs. <u>3</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min. <u>3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>SALISBURY MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Philip Todd</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Langen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT Address <u>Mr Philip Todd, Berlin MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity (Birth wt 620 gms)</u> DUE TO <u>776X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/1/61</u> , 19 <u>61</u> , to <u>4/3</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>4/2</u> , 19 <u>61</u> , and that death occurred at <u>4:25</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Alfred C. Kolls</u> M.D.		ADDRESS (Street, city or town, state) <u>Medical Center</u> DATE SIGNED <u>4/3/61</u>	
PHYSICIAN'S NAME (Type) <u>Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/4/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>	22d. LOCATION (City, town, or county) (State) <u>Berlin Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Amos A. Burdette</u> ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR <u>DATE APR 6 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2082-393XV0

CERTIFICATE OF DEATH

WILLIAM J. BROWN
BORN 1870
DIED 1910

WILLIAM J. BROWN
BORN 1870
DIED 1910

WILLIAM J. BROWN
BORN 1870
DIED 1910

WILLIAM J. BROWN
BORN 1870
DIED 1910

WILLIAM J. BROWN
BORN 1870
DIED 1910

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WILLIAM J. BROWN
BORN 1870
DIED 1910

WILLIAM J. BROWN
BORN 1870
DIED 1910

WILLIAM J. BROWN
BORN 1870
DIED 1910

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#1
Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4972
MAYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04960

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland		c. LENGTH OF STAY IN 1b X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Main St		d. STREET ADDRESS Main St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDWIN Middle WARFIELD Last TOWNSEND		4. DATE OF DEATH Month APRIL Day 14th Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 13, 1903
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Marion Station (Som. Co.) Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Perry Edwin Townsend		14. MOTHER'S MAIDEN NAME Mary Frances Townsend	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT Mrs. Fannie M. Townsend (Mother) Address Main St Fruitland, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) Arterio Sclerotic Heart Disease DUE TO (c) years		INTERVAL BETWEEN ONSET AND DEATH years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a. m. N/A 19 19 p. m. N/A		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) N/A (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-17 19 55 to 4-14 19 61 , that (I) (we) last saw the deceased alive on 1-6 19 61 , and that death occurred at 3:00 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Earl L. Royer		22b. DATE SIGNED April 15 / 1961	
22c. PHYSICIAN'S NAME (Type) Dr. Earl L. Royer		22d. ADDRESS 407 Camden Ave. Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 16/61	
23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		25a. REC'D BY REGISTRAR APR 18 '61	
ADDRESS SALISBURY MARYLAND		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

1. Name of Deceased: [Illegible]
2. Sex: [Illegible]
3. Age: [Illegible]
4. Date of Birth: [Illegible]
5. Date of Death: [Illegible]
6. Place of Death: [Illegible]
7. Cause of Death: [Illegible]
8. Signature of Physician: [Illegible]
9. Signature of Registrar: [Illegible]
10. Date of Registration: [Illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4973

04961

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 56 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Deer's Head State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Somerset ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield d. STREET ADDRESS 118 Somerset Avenue (118) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mabel Middle F. Last Townsend		4. DATE OF DEATH Month April Day 20 Year 19 61		5. SEX Female			
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 20, 1894			
9. AGE (In years last birthday) 67 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Crisfield, Maryland			
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Travis Somers		14. MOTHER'S MAIDEN NAME Virginia Elliott			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT John S. Townsend, 118 N. Somerset, Crisfield, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent cerebral thrombosis DUE TO (b) 332X Conditions, if any, which gave rise to immediate cause (c) 332X DUE TO (e) 332X (f) 332X (g) 332X (h) 332X (i) 332X (j) 332X (k) 332X (l) 332X (m) 332X (n) 332X (o) 332X (p) 332X (q) 332X (r) 332X (s) 332X (t) 332X (u) 332X (v) 332X (w) 332X (x) 332X (y) 332X (z) 332X							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia, bilateral							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 61 Hour a.m. 10:50 A.M. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Crisfield (County) Maryland (State) Md							
21. I certify that (I) this hospital attended the deceased from Feb. 23, 1961 , to April 20, 1961 , that (I) (we) last saw the deceased alive on April 20, 1961 , and that death occurred at 10:50 A.M. from the causes and on the date stated above.							
22a. SIGNATURE 22b. DATE SIGNED 4/20/61							
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D. 22d. ADDRESS Deer's Head State Hospital; Salisbury, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/23/61		23c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery			
23d. LOCATION (City, town or county) Crisfield, Maryland (State) Md		24 FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Maryland					
25a. REC'D BY REGISTRAR APR 26 1961		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Maldve</i>					

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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 15M 9/60

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Salmon

Heart's 1000 1000 1000

Label

Township

Jan. 20, 1921

Whitfield, Virginia

Virginia 1000

John S. Lawrence, 178 S. Lawrence, Virginia

Recorded 1000 1000

Whitfield, Virginia

Vol. 2, 1000 1000

Vol. 2, 1000 1000

Label

John's 1000 1000 1000

Whitfield, Virginia

Whitfield, Virginia

Label

Whitfield, Virginia

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4974

04962

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Somerset		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY in lb 63 days		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Deer's Head State Hospital			d. STREET ADDRESS Chance		
3. NAME OF DECEASED (Type or print) Oscar Francis Travers			4. DATE OF DEATH Month April Day 4 Year 19 61		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1901		9. AGE (In years last birthday) 59 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood	11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James Travers			14. MOTHER'S MAIDEN NAME Ellen Messick		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Grace Travers Address Chance, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Slit Blastoma of Brain DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH 1 year
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from Jan. 31 , 19 61 , to April 4 , 19 61 that (I) (we) last saw the deceased alive on April 3 , 19 61 , and that death occurred at 12:40 A.M. from the causes and on the date stated above.					
22a. SIGNATURE Lee L. Lawry M.D.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4/4/61
22c. PHYSICIAN'S NAME (Type) Lee L. Lawry, M. D.			22d. ADDRESS Deer's Head Hospital; Salisbury, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF Apr. 6, 1961	23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	23d. LOCATION (City, town or county) Chance	(State) Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE L. S. Webster ADDRESS Princess Anne, Md.			25a. REC'D BY REGISTRAR DATE APR 10 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Klaus	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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Salisbury

Dear Mr. [Name]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4975

04963

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLYDE Middle GILBERT Last TRUITT		4. DATE OF DEATH Month 4 Day 15 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 29, 1887
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Telephone Co.		10b. KIND OF BUSINESS OR INDUSTRY Telephone	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Truitt		14. MOTHER'S MAIDEN NAME Mary Elizabeth White	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W.I		16. SOCIAL SECURITY NO. 312-10-0712	
17. INFORMANT Mrs. Grace P. Truitt, Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cornary Strangulation 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-12-61 to 4-15-61 , that (I) (we) last saw the deceased alive on 4-14-1961 , and that death occurred on 4-15-1961 at 1:05 PM from the causes and on the date stated above.			
22a. SIGNATURE Philip A. Insley		22b. DATE SIGNED 4-17-1961	
22c. PHYSICIAN'S NAME (Type) Dr. Philip A. Insley		22d. ADDRESS Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-18-1961	
23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland		25a. REC'D BY REGISTRAR DATE APR 19 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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4976

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04964

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Patrick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Dallas Bond St. (Apt-House)				d. STREET ADDRESS (Unk)			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First EDWIN Middle EVERETT Last TURNER				4. DATE OF DEATH Month APRIL Day 15th Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Feb. 16, 1885	
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min.		11. IF UNDER 24 HRS. Months 76 Days 76 Hours 76 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Station Operator (Retired)				10b. KIND OF BUSINESS OR INDUSTRY Virginia			
11. BIRTHPLACE (State or foreign country) U S A				12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Murry Turner				14. MOTHER'S MAIDEN NAME Sarah Rangely			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk				16. SOCIAL SECURITY NO. Unk			
17. INFORMANT Dr. James H. Turner (Son)				Address 5517 Nicholson St E. Riverdale, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral passive Lung congestion DUE TO Cardiac failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ch. Bronchiectasis DUE TO (c) Ch. Bronchiectasis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A			
20c. TIME OF INJURY Month, Day, Year Hour o. m. N/A p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A				20f. (City or town) (County) (State) N/A			
21. I certify that (I) (this hospital) attended the deceased from 4/15/1961 to 4/15/1961 , that (I) (we) last saw the deceased alive on 4/15/1961 , and that death occurred on 4/15/1961 at 8:00 A.M. , from the causes and on the date stated above.							
22a. SIGNATURE W. B. Smith				22b. DATE April 15/1961			
22c. PHYSICIAN'S NAME (Type) Dr. William B. Smith				22d. ADDRESS Medical Center Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Apr/17/61			
23c. NAME OF CEMETERY OR CREMATORY Stuart Cemetery				23d. LOCATION (City, town, or county) (State) Stuart, Virginia			
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				25a. REC'D BY REGISTRAR APR 18 '61			
25b. REGISTRAR'S SIGNATURE Arthur S. Hines							

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CERTIFICATE OF DEATH

Patricia

Virginia

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Married - 1908

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Home of (A. T. Jones)

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury 12			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kiowa Ave.				d. STREET ADDRESS Kiowa Ave. Salisbury Md.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First George Middle M. Last Twilley				4. DATE OF DEATH Month April Day 9 Year 1961			
5. SEX M.		6. COLOR OR RACE C.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 15, 1886	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 74 Days 74 Hours 74 Min.		IF UNDER 24 HRS. Months 74 Days 74 Hours 74 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George Ballard				14. MOTHER'S MAIDEN NAME Anna Twilley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. INFORMANT Address Mrs. Anna Price Kiowa Ave. Salisbury Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Hypertensive Cardiopulmonary DUE TO Renal Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 1 yr. 2 mo.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 10 Apr 1960 to 9 Apr 1961 that I last saw the deceased alive on 7 Apr 1961 , 19 61 , and that death occurred at 7 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Purnell M.D.				ADDRESS (Street, city or town, state) 6826 Ma Salisbury Md.			
DATE SIGNED 14 Apr 61							
PHYSICIAN'S NAME (Type) E A PURNELL							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4/13/1961		22c. NAME OF CEMETERY OR CREMATORY Rockawalking		22d. LOCATION (City, town, or county) (State) Rockawalking Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Clinton F. Stewart Salisbury Md. ADDRESS				24a. REC'D BY REGISTRAR DATE APR 17 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kious	

CERTIFICATE OF DEATH

1911

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4978

CERTIFICATE OF DEATH

Reg. Dist. No. 04966

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springhill Sanitarium				d. STREET ADDRESS 704 Second Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Hattie Middle M. Last Walls				4. DATE OF DEATH Month April Day 7 Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 23, 1881	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME E. Filmore Merrill				14. MOTHER'S MAIDEN NAME Harriett E. Clarke			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT William F. Merrill Address 702 Second Street Pocomoke City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure DUE TO Cholangitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pyelonephritis, Acute (c) Pyelonephritis, Acute							INTERVAL BETWEEN ONSET AND DEATH 2 wks 3 mos 3 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Arteriosclerosis with encephalomalacia							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month 12 Day 25 Year 1961 Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12/25 , 19 61 , to 4/7 , 19 61 , that I last saw the deceased alive on 4/6 , 19 61 , and that death occurred at 7:45 A. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Rufus S. Gardner Jr. M.D.				ADDRESS (Street, city or town, state) Pinebluff Rd. Salisbury, Md.			
DATE SIGNED 4/7/61							
PHYSICIAN'S NAME (Type) Rufus S. Gardner Jr.				Salisbury, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-9-61		22c. NAME OF CEMETERY Salem Methodist		22d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert H. Watson				ADDRESS Pocomoke City, Md.		24a. REC'D BY REGISTRAR DATE APR 10 '61	
				24b. REGISTRAR'S SIGNATURE Ciriberto S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Reg. Dist. No.

04967

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Del.</u> b. COUNTY <u>Sussex</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>1/2 hr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>46X - 2</u>	
3. NAME OF DECEASED (Type or print) <u>Albert</u> First <u>Charles</u> Middle <u>WARREN</u> Last		4. DATE OF DEATH Month <u>APRIL</u> Day <u>10</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 25, 1905</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Police</u>		9. AGE (In years lost birthday) <u>56</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
13. FATHER'S NAME <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14. MOTHER'S MAIDEN NAME <u> </u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>246-32-0672</u>		INFORMANT <u>Tsan Larsen</u> Address <u>Rehoboth, Del.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-10-61</u> , 19 <u>61</u> , to <u>4-10-61</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>4-10-61</u> , 19 <u>61</u> , and that death occurred at <u>11:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>4-10-61</u>			
ACTUAL SIGNATURE <u>Willie R. Ellis, Jr.</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 20, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Red Men's</u>		22d. LOCATION (City, town, or county) (State) <u>Selbyville Del.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Watson</u>		ADDRESS <u>Pocomoke City, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 13 '61</u>		24b. REGISTRAR'S SIGNATURE <u>William R. Ellis</u>	

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1545-55-240

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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4980

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04968

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b Since 5/5/60	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pine Bluff State Hospital		d. STREET ADDRESS --	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Ryall Last Webster		4. DATE OF DEATH Month April Day 24 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 22, 1878
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 82 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hiram Webster		14. MOTHER'S MAIDEN NAME Louisa Windsor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Records of Pine Bluff State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 6:54a		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 5, 1960 to April 24, 1961 , that (I) (we) last saw the deceased alive on April 22, 1961 , and that death occurred at 6:54a M, from the causes and on the date stated above.			
22a. SIGNATURE E. P. Ritchings		22b. DATE SIGNED 4/24/61	
22c. PHYSICIAN'S NAME (Type) E. P. Ritchings, M.D.		22d. ADDRESS Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-26-61	
23c. NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery		23d. LOCATION (City, town, or county) (State) Wenona Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Leroy Webster		25a. REC'D BY REGISTRAR DATE APR 26 '61	
ADDRESS Deal Island Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

CENTRAL OF TEXAS

1920

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(1)

January 1920

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

4981
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04969

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital			d. STREET ADDRESS Route # 2		
3. NAME OF DECEASED (Type or print) First Frank Middle Charles Last Widdowson			4. DATE OF DEATH Month 4 Day 30 Year 61		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 17, 1941		9. AGE (In years last birthday) 20 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10b. KIND OF BUSINESS OR INDUSTRY COLLEGE		11. BIRTHPLACE (State or foreign country) PRINCESS ANNE MD	
12. CITIZEN OF WHAT COUNTRY? U. S. -			13. FATHER'S NAME FRANK A. WIDDOWSON		
14. MOTHER'S MAIDEN NAME BETTY ADAMS			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		
16. SOCIAL SECURITY NO. N/A			17. INFORMANT Mr. F. A. Widdowson		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of skull DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 8/14X DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Driving motorcycle and collided with a pony.			INTERVAL BETWEEN ONSET AND DEATH Sudden		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Driving motorcycle and collided with a pony.			20c. TIME OF INJURY Month, Day, Year 12:45 P.M. 4-30-61		
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		
20f. (City or town) Berlin			20g. (County) Worcester		
20h. (State) Md.			21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		
ACTUAL SIGNATURE Earl L. Royer			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Earl L. Royer, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED 5-1-61		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			22b. DATE THEREOF 5/4/61		
22c. NAME OF CEMETERY OR CREMATORY EVERGREEN			22d. LOCATION (City, town, or country) BERLIN MD		
23. FUNERAL DIRECTOR Anna A. Burbage			24a. REC'D BY REGISTRAR May 5 '61		
24b. REGISTRAR'S SIGNATURE Arthur S. Farris			24c. ADDRESS (Street, city, town, or county) Berlin Md		

MEDICAL CERTIFICATION

RECEIVED
MAY 11 1961

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Wichita
Salisbury

Wichita, Kansas

Frank Campbell
Wichita, Kansas

4-21-61

June 17, 1961

STUDENT

Letter to

Subject

President of the

Exhibit motorcycle and collided with a car.

12:45 P.M. 4-21-61

4-21-61

Wichita, Kansas

101 South Ave.

Wichita, Kansas

Wichita, Kansas

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04970

4982

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>Willords</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>J.</u> Last <u>Wilkins</u>				4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 27, 1911</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plant Supt.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Wilkin</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Bradford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-18-4344</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Artery Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO <u>Coronary Artery Thrombosis</u> (c) <u>420.1</u> DUE TO <u>Coronary Artery Thrombosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1</u> , 19 <u>61</u> , to <u>April 2</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>April 2</u> , 19 <u>61</u> , and that death occurred at <u>10:28</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David Gilman</u>				DATE SIGNED <u>4/2/61</u>			
PHYSICIAN'S NAME (Type) <u>Salisbury, Md.</u>				ADDRESS (Street, city or town, state)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>4/5/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Hope</u>		22d. LOCATION (City, town, or county) (State) <u>Willords Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elmer W. Waddy</u>				24a. REC'D BY REGISTRAR <u>APR 6 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
04971									
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b 160 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			12	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital					d. STREET ADDRESS 1507 Laurel Drive			a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Mary Middle Ellen Last Wilkinson		4. DATE OF DEATH Month April Day 11 Year 19 61					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 12, 1879		9. AGE (In years last birthday) 81 yrs.	
						IF UNDER 1 YEAR Months 8 Days 29		IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work -Retired			10b. KIND OF BUSINESS OR INDUSTRY None			11. BIRTHPLACE (County & State, or foreign country) Wicomico County Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Isaac Hearn					14. MOTHER'S MAIDEN NAME Ellen Henry				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. No		17. INFORMANT Mr. F. Morris Wilkinson (Son) (Lakewood) Salisbury, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardiovascular dis. 443 X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old cerebral thrombosis								INTERVAL BETWEEN ONSET AND DEATH Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A						
20c. TIME OF INJURY Month, Day, Year Hour e.m. N/A p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> N/A		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) N/A		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 2, 1960 to Apr. 11, 1961 , that (I) (we) last saw the deceased alive on April 11, 1961 , and that death occurred at 6:40 P.M. from the causes and on the date stated above.									
22a. SIGNATURE L. V. Maldve, M. D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS Deer's Head State Hospital; Salisbury, Md.		22b. DATE SIGNED 4/12/61		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 14, 1961		23c. NAME OF CEMETERY OR CREMATORY Spring Hill Memory Gardens-Salisbury, Maryland			23d. LOCATION (City, town or county) (State) Salisbury, Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY SALISBURY MARYLAND				25a. REC'D BY REGISTRAR APR 14 '61		25b. REGISTRAR'S SIGNATURE Ciribus S. Knead			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4984

04972

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield	
c. LENGTH OF STAY IN 1b 685 days		d. STREET ADDRESS RFD # 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nancy Middle Jane Last Wilson		4. DATE OF DEATH Month April Day 24 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1878
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 24 Days 19 Hours 61 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Garment	11. BIRTHPLACE (County & State, or foreign country) Crisfield, Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Dow Byrd	
14. MOTHER'S MAIDEN NAME Rachel Sterling		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) None	
16. SOCIAL SECURITY NO. 212-10-4915		17. INFORMANT Linwood Wilson, 116 Chesapeake, Crisfield, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 450.0 IMMEDIATE CAUSE (a) Arteriosclerosis, general DUE TO Conditions, if any, which gave rise to immediate cause (b) 450.0 (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)		INTERVAL BETWEEN ONSET AND DEATH Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (b) (this hospital) attended the deceased from June 9, 19 59 to April 24, 19 61 that (I) (we) last saw the deceased alive on April 24, 19 61 and that death occurred at 1:45 P.M. from the causes and on the date stated above.			
22a. SIGNATURE L. V. Maldve, M. D.		22b. DATE SIGNED 4/24/61	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Deer's Head Hospital; Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/27/61	23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery	23d. LOCATION (City, town or county) (State) Crisfield, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Maryland		25a. REC'D BY REGISTRAR MAY 1 61	
25b. REGISTRAR'S SIGNATURE Arthur S. Howard			

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